DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505096	A. BUILDING _____ B. WING _____	C 10/14/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOPPENISH NURSING & REHAB CENTER	802 WEST THIRD STREET TOPPENISH, WA 98948

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F 000	INITIAL COMMENTS This report is the result of an unannounced Abbreviated Survey conducted at Toppenish Nursing & Rehab Center on 10/14/13. A sample of 3 residents was selected from a census of 62. The sample included 2 current residents and the record of 1 former and/or discharged resident. The following complaint was investigated as part of this survey: #2889425 The survey was conducted by: [redacted] R.N. The survey team was from: Department of Social & Health Services Aging & Long-Term Support Administration Division of Residential Care Services, District 1, Unit D 3611 River Road, Suite 200 Yakima, WA 98902 Telephone: (509) 225-2800 Fax: (509) 574-5597 10/25/13 Residential Care Services Date	F 000		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING	F 309		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 309	Continued From page 1 Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to: A) have a system in place to evaluate whether goals related to the number of bowel movements (BMs)/stools and consistency of the stools were met or unmet to ensure the resident's well-being was not compromised and B) maintain a system to monitor and ensure appropriate care and use of a pleurex tube (a tube placed in the chest to allow withdrawal of fluids accumulating in a space adjacent to the lung) and amount of fluids withdrawn were in accordance with the physician's order(s). Instead of being sufficiently prepared to provide care for the resident's pleurex tube, facility staff initially depended on the resident's spouse to perform the draining procedure, provide training materials, and even provide supplies on occasion. Deficient practice was identified for 1 of 3 sampled residents (#1) experiencing changes of condition. Findings include: A) Bowel Movement Monitoring: Resident #1: Review of the medical record revealed the resident was admitted from an acute care hospital on [redacted]/13 with multiple diagnoses including an [redacted] liver condition that impacted his cognitive/brain function low sodium	F 309	1. Resident identified as #1 is no longer residing in our facility. 2. A. Resident's with similar risks will be assessed to ensure physician orders are followed as directed. MARs, TARs, and Care Plans reviewed to ensure comprehensive interventions are in place and implemented accordingly. B. New admits will be thoroughly reviewed prior to admit to ensure supplies needed are in place and are readily available. 3. Staff re-educated regarding documentation expectations with specific focus on bowel management and processing orders completely, which includes modifying individual care plans as appropriate.	11-20-13 11-20-13

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F 309	Continued From page 2 levels, and excessive fluid accumulation. Admission orders included lactulose 30 grams by mouth every three hours when the resident was awake. The hospital discharge summary documented the resident was to have at least 5 BMs per day to maintain good mental function (as it helped lower the ammonia level that impacted cognition). Initial 9/07/13 facility care planning and monitoring documentation directed staff to monitor the frequency of loose stools in relation to the lactulose, "may need to pursue tapering of dosing." According to a 9/07/13 nursing entry the resident had four BMs prior to his hospital discharge that morning. He was scheduled to leave the hospital at noon. A 9/08/13 night shift entry documented the cognitvely alert resident stated he usually had 3-4 BMs a day but had not yet had a BM that night. A bowel report identified one small stool midday but no consistency was noted. A 9/09/13 nursing entry stated the resident was independent with ambulation, transfers, and toileting. No BMs were noted on 9/09/13 and 9/11/13 from the computer generated report and only one BM was documented for 9/10/13. The computer report noted two BMs each day for 9/12/13 and 9/13/13 and no BMs for 9/14/13. There was no assessment of the number of the resident's BMs or the consistency of the stool despite the ongoing administration of lactulose. A 9/14/13 nursing entry documented the resident's spouse had come to the facility to escort him to a meeting that evening.	F 309	4. Daily RV of documentation of new admissions and change in conditions to ensure care delivery meets standard of practice. Weekly random chart reviews to ensure compliance. Identified opportunities for improvement will be presented to the monthly QA until 3 months of consistence compliance.	11-20-13

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F 309	Continued From page 3 When interviewed on 10/15/13 at approximately 10:40 a.m., the resident's spouse recalled (on 9/14/13) she had come to take the resident to a meeting. Resident #1 had reported to her he had been" pooping" 14 times a day. He said it was just like water in consistency. Although she did not actually see the stool, she stated they had to stop at a restaurant both going to and returning from the meeting. He also had to go to the bathroom at the meeting. According to the 9/15/13 nursing entry, on 9/15/13 the resident was walking down the hallway toward the front door with only his shirt on. The resident was "very confused and unable to follow commands." Additionally, the previously continent resident soiled himself and his bedding. The resident hadn't eaten all day but took Gatorade well from his spouse. The lactulose continued as previously ordered. On 9/16/13 the physician reviewed the confused resident's labs, that continued to reveal a low sodium level, and ordered Gatorade to help increase his sodium level. Later during the evening of 9/16/13 Staff Member A, a licensed nurse (LN), documented, "Continues to have frequent bowel movements (sic) resident is independent so difficult to keep track of how many per shift." The computerized bowel record noted one BM on 9/16/13. On 9/19/13 the resident's community specialist physician wrote an order to hold the lactulose and then restart it twice daily and to monitor for diarrhea. On 10/14/13 at approximately 2:55 p.m. Staff Member B, a LN, stated the computerized BM	F 309		

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F 309	Continued From page 4 report did not report a daily total of BMs. The largest reported BM would override reports of any others during a shift. The frequency of BMs should be reported during shift reports. Abnormal findings were to be documented in the nursing progress notes. When interviewed on 10/14/13 at approximately 4:20 p.m. Staff Member A recalled when the resident was cognitively alert he would independently toilet but he also had some incontinence as well at times. There was no system to monitor the number of BMs, it was very challenging to record. B) Pleural Tube: Resident #1: Review of the medical record revealed diagnoses as noted above. During hospitalization the resident had an infection in the pleural fluid. At the time of discharge the resident had the pleurex catheter in place and the cultures were negative for infection. "We are trying not to take fluid off often since he just fills back up again...and this is robbing him of protein. OK to pull fluid off pleurex drain 500 cc (cubic centimeters, approximately 2 cups) at a time if truly dyspnic (having difficulty breathing) or hypoxic (experiencing low oxygen levels), but would not recommend doing this..(blank) since he fills back up after (less than) 24 hrs. (hours). OK to due (sic) less than once per week (more like once every 2 weeks) if really needed." Recommendations from the hospital discharge instructions were incorporated as part of the facility admission orders on [redacted]/13 and added to the treatment record.	F 309		

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F 309	Continued From page 5 A 9/09/13 nursing entry documented the resident's spouse was in and drained the fluid from the pleurex catheter. No amount was noted and there was no notation that the resident was short of breath or hypoxic. Two days later, on 9/11/13, the nursing entry documented the spouse was in to "help drain cath (catheter)." Resident and wife left CD at nurses' station on how cath is drained. When interviewed on 10/14/13 at approximately 2:20 p.m., Staff Member D, a LN, recalled the spouse came in and performed the pleurex draining and she didn't always convey she had completed it and/or reported the amount withdrawn. The spouse also provided a CD for staff training and they signed after they completed it. The physician directives were not to drain the pleurex tube unless the resident was short of breath. Rather than actual shortness of breath, the LN often assessed the resident appeared to be anxious. Review of the 9/14/13 nursing entry by Staff Member C, a LN, revealed the resident stated he needed "to be drained" as he was experiencing shortness of breath as a result of the pressure in his abdomen and chest. Staff Member C documented removing 1100 cc (approximately 4 1/2 cups) of yellow fluid despite the directive not to remove more than 500 cc. The resident directed the LN not to stop until it stopped on its own. A 9/16/13 nursing entry documented the spouse reported she was in daily draining approximately 1000 cc of fluid per day. A new physician's order, dated 9/19/13, noted the	F 309		

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F 309	Continued From page 6	F 309		

pleurex catheter could be drained daily with the removal of 1000 cc daily. However, the 9/2013 treatment record noted 1200 cc was removed on 9/19/13.

Nursing documentation, dated 9/20/13 and 9/21/13, revealed the spouse was notified the facility needed additional supplies for the fluid taps and she stated she would bring them in.

When interviewed on 10/15/13 at approximately 10:40 a.m. the resident's spouse stated she initally performed the tube draining. She then provided the facility with a CD that provided instruction on how to do the procedure. She had obtained it at another hospital prior to his most recent hospitalization. Then both she and the staff LNs were performing the procedure. She recalled reporting to the LN on-duty when she completed the procedure each time.

According to lab results on 9/23/13 the resident had changes in his electrolytes and despite interventions he was transferred to the hospital on 9/27/13 when his condition deteriorated further. He was thought to have an infection in his pleural space.

The facility failed to ensure physician directives were followed pertaining to management of the pleural catheter and withdrawing fluid. Instead, staff were initially dependent on the wife for performance of the procedure at the request of the resident and for staff training on the procedure. Later, the wife provided supplies at the request of facility staff when they lacked necessary supplies for the pleural catheter draining. Care related to the pleural tube was not consistently performed in accordance with

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F 309	Continued From page 7 physician directives.	F 309		